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PAXTON HEALTHCARE AND REHAB	1240 NORTH MARKET STREET PAXTON, IL 60957

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S 000	Initial Comments Complaint # 1664318/IL87414	S 000		
S9999	Final Observations STATEMENT OF LICENSURE VIOLATIONS: 300.610a) 300.1010h) 300.1210a) 300.1210b) 300.1210d)2)3)5) 300.1220b)2)3 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five	S9999	Attachment A Statement of Licensure Violations	

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percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.

Section 300.1210 General Requirements for Nursing and Personal Care
a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)
b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.
d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:
2) All treatments and procedures shall be administered as ordered by the physician.

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3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.
5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.

Section 300.1220 Supervision of Nursing Services
b) The DON shall supervise and oversee the nursing services of the facility, including:
2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.
3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The

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plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These regulations are not met as evidenced by:

Based on observation, record review and interview, the facility failed to identify a pressure ulcer and follow their policy for pressure ulcers and care plans. The facility also failed to follow physician orders for pressure ulcer treatment and provide nutritional interventions for three of three residents (R1, R2, R3) reviewed for pressure ulcers. This failure resulted in R1 acquiring multiple stage 3 pressure ulcers and R2 acquiring three unstageable pressure wounds.

Findings Include:

The facility Skin Condition Monitoring Policy dated 12/29/14 documents, "Residents with skin lesions/wounds will be monitored and documentation will be completed...It is the responsibility of the Charge Nurse to assess any skin conditions that are observed or reported. The Charge Nurse must then notify physician and obtain proper treatment as indicated...When the Charge Nurse is aware of skin lesions, wounds, venous ulcers, or other skin abnormalities, the area is to be assessed and documented. Documentation is to occur on the Skin

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Observation Note...Documentation of the skin condition using the Weekly Wound Tracking Assessment will be done by wound nurse at least once a week until healed. Assessment is to include: Characteristics (i.e. size, depth, color, drainage), presence of granulation tissue, necrotic tissue, treatment and response to treatment, prevention technique (i.e. turning and repositioning, skin care, protective devices)."

The facility Pressure Ulcer Prevention, Identification and Treatment Policy dated 12/29/14 documents, the prevention program will be utilized for all residents who have been identified as being at risk for developing pressure ulcers. "The facility will initiate an aggressive treatment program for those residents who have pressure ulcers....A pressure ulcer is defined as any lesion caused by unrelieved pressure those results in damage to underlying tissue...It is the responsibility of the Charge Nurse to care for pressure areas and provide treatments as ordered....All residents will have a Pressure Ulcer Risk Assessment completed upon admission, then weekly for four weeks, then quarterly...The physician is to be notified when A) pressure ulcer develops, B) when there is a noted lack of improvement after a reasonable amount of time C) and/or upon signs of deterioration...Documentation of the pressure ulcer must occur upon identification and at least once a week until healed. Assessment is to include: Characteristics (i.e. size, depth, color, drainage), presence of granulation tissue, necrotic tissue, treatment and response to treatment, prevention technique (i.e. turning and repositioning, skin care, protective devices)." The undated Pressure Sore Prevention Guidelines and Suggested Interventions, attached to the Prevention Policy documents, "residents

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assessed to be at risk should be placed on pressure reducing bed or mattress. If the sacrum is making contact with the bed mattress through the overlay, pressure relief is not being achieved.

The facility Care Planning Policy dated 8/13/15 documents, "Each resident will have a plan of care to identify problems, needs and strengths that will identify how the interdisciplinary team will provide care...High Risk areas will be care planned on admission...The specific problem as well as the underlying cause should be listed...source re, but not limited to: problems relating to diagnoses, .. dietary and nutritional status problems...problems related to preventive care, all problems identified on all assessments, all problems that require care, and refusal or care and treatment...".

The facility Abuse Prevention Program dated 7/22/15 documents, "Neglect means the failure to provide, or willful withholding of, adequate medical care mental health treatment, psychiatric rehabilitation, personal care, or assistance with activities of daily living that is necessary to avoid physical harm, mental anguish, or mental illness of a resident."

The facilities Dietary Consultation Agreement dated 1/1/16 documents, "To collaborate with the dietary department concerning the following areas: Nutritional Assessment for residents referred by the Facility which may include residents with: ...Pressure Ulcers, Poor Nutritional Intake...".

1. R1's Admit/Readmit Assessment dated 12/9/15 documents R1 was admitted to the facility on 12/9/15 with the following Diagnoses: Candidiasis

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S9999	Continued From page 6 of Skin, Severe Morbid Obesity, Unspecified Protein Malnutrition, Cellulitis of the Abdominal Wall and Venous Insufficiency. This assessment documents, extensive assist is required for bed mobility and R1 is totally dependent of staff for transfers. This also documents, "right iliac crest (front) rash, right iliac crest (front) surgical incision 3.5 cm (centimeters) by 1.0 cm by 0.25 cm, left iliac crest (front) rash, left iliac crest (front) surgical incision 2.5 cm by 0.5 cm by 0.25 cm, groin rash, right shoulder bruising, right wrist bruising." The rash areas were not documented as being measured. R1's was evaluated by Z5 Registered Dietician on 12/14/15 and the Dietary Recommendations documents, R1 "does have a diagnosis of protein-calorie malnutrition, recommendation: add med pass 2.0, 120 cc (cubic centimeters) TID (three times a day) for an extra 720 Kcal (kilocalorie's) and 30 grams of protein." R1's Order Recap Report dated 8/4/16 does not document that this recommendation was ever implemented. On 8/8/16 at 10:10 am, E6 DM (Dietary Manager) stated, after a recommendation is made, those recommendations are given to E2 DON (Director of Nursing) and E2 passes them on to the nurses who write the order, then the recommendation is initiated. On 8/8/16 at 10:30 am, E2 DON confirmed that the dietary recommendation was not on R1's Physician Orders and that R1 had not received the extra protein and stated, "I don't know why." The only Pressure Ulcer Risk Assessment in R1's medical record is dated 12/16/15 and does not document if R1 is at risk for pressure ulcers or not, as the Assessment wasn't completed.	S9999		

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R1's MDS (Minimum Data Set) dated 12/16/15 documents R1 is alert and oriented, is 66 inches tall and weighs 395 pounds and requires extensive assist of two staff is required for bed mobility. This MDS also documents R1 as being at risk for pressure ulcers but did not currently have any.

R1's Care Plan dated 12/23/15 does not address R1 being at risk for skin breakdown or what interventions were in place to prevent skin breakdown, or R1's current rash.

R1's progress from 12/9/15 -1/4/16 do not document that R1 was ever out of bed. On 1/4/16 E7 RN (Registered Nurse) documents, "(R1) complaints for severe pain to back stating, "it feels like my spine is being ripped out", upon investigation what appears to be a rash starting at upper back, continuing to upper thigh region...Notified Z1 NP (Nurse Practitioner) and received N.O. (New Orders) to send pt {patient} to ER (Emergency Room)."

R1's Admit/Readmit Assessment dated 1/7/16 documents R1's coccyx, groin, right and left buttocks "are raw" and "bottom and groin are weeping a serous sanguineous liquid." There are no measurements documented of R1's "raw" areas.

There is no Skin Risk Assessments in R1's clinical record for the time frame following R1's readmit to the facility.

The 8/4/16 Order Recap Report does not document any treatments for R1's "raw areas", upon readmission on 1/7/16 until 1/13/16.

R1's CarePlan dated 1/8/16 documents, "requires

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a three person transfer with 700 pound mechanical lift...needs to be up in the wheelchair twice a day for at least one hour each time." This careplan does not address R1's "raw skin" conditions or the risk for further breakdown.

R1's Progress Notes document:

1/13/16 by E7 document, "noted open areas to left and right buttocks and right upper thigh. N.O. cleanse with wound cleanser, apply silvasorb, and cover with foam daily." There are no measurement of these wounds documented.

1/13/16 - 1/19/16, R1 having pain but getting relief with medication.

1/20/16 by E7, "Assessed open areas...Proximal RLE (right lower extremity) measuring 10.5 x (by) 3.5 x 0 cm with pink wound bed noted and small amount of serous drainage noted. Distal RLE measuring 3 x 2 x 0 cm with pink wound bed noted and small amount of serous drainage noted. Right buttocks measuring 6 x 8 x 0 cm with dark tissue at wound bed and sanguinous drainage noted. Left buttocks measured 8.5 x 4 x 0 cm with red tissue noted at wound bed draining sanguinous drainage. Pt complained of pain during dressing changes, medicated prior to dressing change with PRN (as needed) Norco."

R1's 8/4/16 Order Recap Report documents an order on 1/20/16 for R1 to be referred to the Wound Clinic due to multiple wounds to right abdomen, right and left buttocks and right upper leg.

R1's Progress Notes document:
1/29/16 by E10 RN, "...dressing applied to back.

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No improvement noted. Appears to be somewhat larger. Other sites cleaned and left open to air." There is no documentation of wound measurements or of Z1 or Z6, Physician being notified of wound appearing larger.

1/30/16 by E13 RN, "remained in bed all evening. Alert but confused at times, seeing imaginary people in the other bed. Stating (R1) has heard a dog all night." There is no documentation of Z1 or Z6 being notified of R1's change of status.

2/3/16 "....Order received per (Z1) to send to ED (Emergency Department)."

There is no documentation in R1's Progress Notes that R1 was ever seen at the Wound Clinic.

R1's Hospital Progress Notes dated 2/4/16 documents, R1 was seen per wound care consult and has the following wounds: left lower back measuring 7.0 x 20.0 x unknown depth due to being covered with 90% eschar, left upper hip measuring 5.5 x 5.0 x 0.2 cm, bilateral buttocks and upper inner thighs are bright red but blanchable, left buttocks stage 3 pressure ulcer measuring 4.0 x 2.0 x 0.1 cover with 90% slough, several stage 3 pressure ulcers on the right buttocks measuring an area of 5.5 x 2 x unknown depth due to being covered with 100% slough.

R1's Surgical Report dated 2/10/16 documents, "(R1) had multiple superficial Decubitus of the lower back and thighs. (R1) had one across the mid portion of the back, mostly on the left side and some on the right measuring about 14 cm, which was excisionaly debrided...roughly about 14 x 5 cm with about 4-5 cm deep into the tissue...wound vac applied."

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On 8/3/16 at 2:00 pm, E1 Administrator stated, "we don't have a policy regarding cares for a bariatric resident, we would provide the same cares as we do for everyone just on a larger scale, a bigger wheelchair, bigger bed, that type of stuff. I know we ordered special equipment for (R1) at some point."

On 8/4/16 at 9:25 am, Z4 COTA (Certified Occupation Therapy Assistant) stated, R1 was a large lady who stayed in bed at all times. R1 was admitted with a "horrible rash that went down both sides of back, onto the back of the legs,.. (R1) was very excoriated. (R1) ended up with open wounds on (R1)'s backside. (R1) would even do therapy the majority of the time while lying in bed or sitting on the side of the bed, (R1) just refused to get up." Z4 stated, "they {nursing staff} said (R1) was on a pressure relieving mattress but it wasn't an air mattress, that might have helped...I know staff were repositioning (R1) every couple hours but I don't know what else they were doing for (R1) to prevent the breakdown."

On 8/4/16 at 10:45 am, E7 stated R1's wounds "were a big problem. (R1) was sent to the hospital a few times and returned with treatments for yeast infection but they kept getting worse. (R1) would refuse to get up out of bed at that time. (R1) was admitted to the hospital for treatment once the pain got so bad and when (R1) returned, (R1's) skin looked much better. I then took over as wound nurse and noticed nothing was being done for (R1's) open areas, they were just being left open to air, that is why I called and got the treatment order on 1/13/16. (R1's) wounds kept getting worse, even with the treatment so I got an order to send (R1) to the wound clinic on 1/20/16. (R1) still wasn't getting up and out of bed a lot

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because (R1) needed three people to assist with the mechanical lift and a lot of times, we didn't have that much help. We would reposition (R1) every few hours but that really wasn't helping."

R1 was evaluated by Z5 Registered Dietician on 12/14/15. Z5 made Dietary Recommendations which document, R1 "does have a diagnosis of protein-calorie malnutrition. Recommendation: add med pass 2.0, 120 cc (cubic centimeters) TID (three times a day) for an extra 720 Kcal (kilocalorie's) and 30 grams of protein." R1's Order Recap Report dated 8/4/16 does not document that this recommendation was ever implemented.

On 8/4/16 at 1:30 pm, Z5 RD (Registered Dietician) stated, Z5 is at the facility usually at least once and week and assesses and makes needed recommendations for all new admissions and residents with skin issues. Z5 confirmed that a recommendation was made for R1 on 12/16/16 and should have been implemented, and that was the only time an assessment was done. Z5 did not assess R1 after R1's rash opened up into open pressure ulcers, per facility policy.

On 8/4/16 at 2:50 pm, E2 DON confirmed R1 only had one skin risk assessment completed while in the facility. E2 stated, "skin risk assessments are completed upon admission and then quarterly." E2 was not aware the the facility policy stated these assessments would be completed upon admission, weekly times 4, then quarterly. On 8/4/16 at 2:50 pm, E2 DON stated, E2 was not employed at the facility when R1 was a resident but for someone in R1's condition, E2 would expect the staff to turn and reposition frequently, at the minimum of every 2 hours, apply all treatments that were ordered, notify the physician

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with any changes in skin condition, measure all wounds weekly and upon development and get a treatment order from the physician and assess the residents for risk upon admission and quarterly with the MDS. E2 was not aware that the facility policy documents that skin risk assessments needs to be done on admission, weekly times 4, then quarterly. E2 stated E2 felt like the mattress that R1 used upon admission would have been appropriate for R1.

The undated Group 1 Therapeutic Support Surfaces grid, provided by E1 Administrator documents the type of mattress R1 was using at the time of admission was a Prevention Dual-Layer Foam Mattress for low- medium risk residents weighing 350 - 400 pounds.

On 8/4/16 at 3:20 pm, E6 DM stated, E6 was informed of skin issues during weekly skin and weight meetings. Anybody with skin issues is then referred to Z5 to be assessed and recommendations made. E6 was unsure why R1 was not re-assessed by Z5 upon acquiring pressure ulcers, "(R3) should have been."

On 8/8/16 at 9:28 am, E3 MDS Coordinator stated, R1 was "definitely at high risk for skin breakdown due to (R1's) size." R1 was non-compliant with cares, always in bed, and was incontinent of urine. E3 stated, R1 was on a regular bariatric mattress. E3 also stated, R1 should have had a careplan for R1's rash and being at high risk for skin breakdown. E3 stated, "I was new at the time of (R1's) admit and I was just getting to know (R1), I just over looked it."

On 8/8/16 at 11:50 am, Z3 (medical equipment sales representative) stated, "the facility ordered a special bariatric mattress and bed on 1/25/16

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{1.5 months after (R1) was admitted to the facility}, I don't know who that was for." The mattress description documents, a multi layered foam mattress with a high density bottom layer that supports up to 750 pounds, it does not document the classification and specs for what stage of pressure ulcers the mattress is approved for."

On 8/8/16 at 3:30 pm, E1 Administrator confirmed that the order that was placed on 1/25/16 was for a new mattress for R1.

On 8/8/16 at 11:20 am, Z1 NP stated, "(R1) was a tough patient. (R1) was completely non-compliant, and (R1) refused to get up out of bed. The mattress the facility had (R1) on was not the correct one, mattresses need to change according to the residents needs and (R1) should have been on an air mattress from the beginning. That should be an automatic with residents like this, not getting up out of bed. I can't say if getting the extra protein (that Z5 had recommended) would have prevented the wounds or healed them, but it absolutely would have helped."

2. R3's undated face sheet documents R3 was readmitted to the facility on 6/13/16.

R3's only pressure ulcer risk assessment, since recent admission, dated 6/13/16 documents, "high risk for breakdown."

The facility Skin Condition Report dated 8/2/16 documents R3 has excoriation to bilateral posterior thighs that was acquired on 7/21/16. Right thigh excoriation measuring 2.5 x 3 x 0.1

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cm and Left thigh excoriation measuring 1 x 1.5 cm scab and 1 x 1.5 cm blister.

R3's Medication Review Report documents a treatment order for : 7/21/16 - cleanse bilateral posterior thighs with wound cleanser, apply silvasorb and cover with foam everynight; for excoriation.

On 8/4/16 at 9:55 am, R3 was sitting in a wheelchair slouched down with head resting on the back of wheelchair. R3 stated, "I'm sitting like this because if I sit upright, it hurts the back of my legs", while pointing to posterior thigh. E8 and E9 CNA's (Certified Nursing Assistants) attached the mechanical lift to a sling that was under R3 and lifted R3 from the wheelchair into the bed. The sling edge was on the area that R3 had just pointed to. Once in bed, E8 and E9 removed R3's pants exposing gauze wraps around R3's right and left upper thigh, just above R3's knees, the location that R3 had pointed to and stated was painful. These gauze wraps encircled R3's thighs and were wet with a yellowish liquid from the outer thigh area, around the posterior side, and to the inner thigh area. E8 stated, R3 is on dialysis so R3 rarely urinates. E7 RN stated, "it looks like drainage from the wounds to me." E7 removed the gauze wraps to provide the ordered treatment for excoriation. R3's right posterior thigh was purplish in color and had eight open areas. E7 stated, "we think this was caused by the pressure from the mechanical lift sling, (R3's) legs didn't look like this..(R3) didn't have any open areas to upper thighs before we started using it a few weeks ago." E8 confirmed E7's statement. E7 described the wounds and stated, "this area is approximately 2 x 2 cm", pointing to one of the open wounds. It was covered with gray slough. E7 pointed to another area that was covered in

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yellow slough and stated, "this is approximately 5 x 0.5 cm, it would be considered unstageable, just like the last one since you can't see the wound bed." E7 pointed to a third area and stated, "approximately 4 x 6 cm and would be a stage 2 like all the other smaller ones {wounds on the thigh}, since you can see the wound bed." R3's left posterior thigh was purplish in color and flaky and had 7 open wounds. E7 stated, this is the worst on this leg, while pointing to a wound that was covered in yellow slough. E7 stated, "it is approximately 5 x 0.5 cm. It would be an unstageable also." When asked it they had tried a different sling as to not cause pressure on R3's legs, E9 stated, "this is the only type of sling we {facility} have. It doesn't help the situation that (R3) doesn't like to lay down and (R3) is up in the wheelchair all day." R3's wheelchair had a cotton cushion, for a regular straight back chair, in the seat but not a pressure reducing cushion.

On 8/4/16 at 10:45 am, E7 stated, the wounds on R3's legs were "not classified as pressure ulcers", even though they thought it was caused from the mechanical lift sling because, R3 has a history of stasis ulcers to the lower legs also so they {facility} "didn't know how to classify the wounds." E7 stated, "I used to be the wound nurse up until this week then (E11 RN) took that over. (R3's) wounds are getting worse though, (R3) has three unstageable pressure ulcers now and multiple stage 2." E7 stated R3's condition had been discussed with E2 DON and that E2 suggested padding the sling to alleviate some of the pressure. E7 stated, "I told the CNA's but not sure if they have been doing it, it wasn't padded today."

There are no Dietary Assessments completed and documented in R3's record since the

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development of the pressure ulcers, per their policy.

On 8/4/16 at 1:30 pm, Z5 RD stated, R3 is seen frequently but has not assessed since the end of June. Z5 was not aware that R3 had any open areas. Z5 stated, "I am at the facility at least weekly and would have reviewed the information and made recommendations had I known."

On 8/4/16 at 2:50 pm, E2 DON stated, all residents are assessed for risk of skin breakdown upon admission and quarterly with the MDS. E2 was not aware that the facility policy documents that skin risk assessments need done on admission, weekly times 4, then quarterly. E2 confirmed instructing staff to pad the mechanical lift sling for R3 and was not aware that it wasn't being done.

3. R2's MDS dated 7/6/16 documents R2 is alert and oriented, is at risk for pressure ulcers and was admitted to the facility with one stage 2 pressure ulcer.

The facility Weekly Skin Record dated 6/30/16 documents, admitted with a stage 2 pressure sore to the left outer aspect of first digit measuring 0.5 x 0.4 x 0 cm.

R2's Care Plan dated 6/29/16 documents, "stage 2 pressure ulcer to the left foot...keep pressure off affected area as much as possible, notify MD (Medical Doctor) of any new skin issues or of any changes, administer treatment as ordered."

R2 has only one Skin Risk Assessment in R2's clinical record. The assessment dated 7/6/16

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documents, "low risk for skin breakdown."

R2 was seen by Z2 Wound Physician on 7/15/16. The Physician Orders and Patient Discharge Instructions document, "Wound: left foot outside edge: cleanse and dry with soap and water or wound cleanser, apply moisture barrier cream-thin layer around outside edges of wound, cover wound with foam square and tape, wear protective shoe or tennis shoe....eat more protein."

On 8/3/16 at 11:15 am, E7 RN removed an (adhesive bandage) from R2's left outer foot, there was no foam under the (bandage). R2's wound and surrounding skin was white and macerated. E7 cleansed the wound, applied skin barrier cream around the wound and reapplied a (bandage). E7 stated, R2 doesn't like the foam, R2 hasn't allowed us to put it on in several weeks. R2 stated, "it hurts so I don't want it." E7 stated, "I have not updated the physician on his refusal of ordered treatment, we've just been putting a (bandage) on it."

R2's Medication Review Report documents an LCS (Low Concentrated Sweet) diet. There are no added supplements or extra protein ordered.

On 8/4/16 at 1:30 pm, Z5 RD stated, Z5 completed R2's Nutrition Assessment on 7-5-16. "I did not realize (R2) was admitted the facility with a pressure ulcer. I would have made recommendations for extra protein with help with healing." When told of Z2's recommendations on 7/15/16 that were not implemented, Z5 stated, "I would have recommended a House Supplement to be given a few times a day for the extra protein, but I was not aware of (Z5's) orders."

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S9999	Continued From page 18 On 8/4/16 at 2:50 pm, E2 DON stated, all residents are assessed for risk of skin breakdown upon admission and quarterly with the MDS. E2 was not aware that the facility policy documents that skin risk assessments need done on admission, weekly times 4, then quarterly. On 8/4/16 at 3:20 pm, E6 DM confirmed R2 had not been getting extra protein and stated, "we {dietary} never got this recommendation from the nurses." (B)	S9999		